50 McAndrews Road East Burnsville, MN 55337
952-892-5050

WELCOME

We are committed to pursuing excellence through continuing education, personal and team growth and mastery of leading edge technology. It is our goal to hold firmly to lasting relationships we have established with our patients, while looking forward to relationships yet to be built.

PATIENT INFORMATION

Patient Name ________________________ Preferred Name ____________

SSN ________________________ Sex M F DOB________ Age _____

Address ____________________ Email ________________

City ____________ State _____ Zip ________ Ph#____________ Home/ Cell

Patient's School/ Employer ______________________ Student Status PT FT

How did you hear about our office? (Please circle one) * Family/Friend * Drive by *Insurance *Other

- By providing your cellphone number or email an automatic confirmation will be sent to you.

EMERGENCY CONTACT INFORMATION

❖ PRIMARY CONTACT

Name ________________________ DOB __________ Relation____________

Employer ________________________ Sex M F

Home (______)______________ Cell (_____) ______________ Work (_____)____________

❖ SECONDARY CONTACT

Name ________________________ DOB __________ Relation____________

Home (______)______________ Cell (_____) ______________ Work (_____)____________

INSURANCE INFORMATION

Will you be using dental insurance for your visit today? Yes No

If yes, please indicate the insurance information below.

PRIMARY INSURANCE

Subscriber ______________________ Relationship to patient ________________ DOB ___________

Insurance company name ____

Employer ___________________________ ID# _____________________ Group# _____________

SECONDARY INSURANCE

Subscriber ______________________ Relationship to patient ________________ DOB ___________

Insurance company name ____

Employer ___________________________ ID# _____________________ Group# _____________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ________________ and assign directly to Crestridge Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office may use my health care information and may disclose such information to the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Court fees and 1.5% monthly interest charges will be applied to any delinquent accounts.

____

(Signature of Patient, Parent, Guardian or Personal Representative)

Adult Medical History

Patient Name ______________________ D. O. B ______________________

Emergency Contact (Name/ Phone Number) ______________________

Medical History

1. Physician ______________________ Address ______________________
2. When was your last physical examination? ______________________
3. Are you under the care of a physician? .... Yes ◯ No ◯
   If yes, for what reason(s)? ______________________
4. Are you presently taking any medications/drugs/pills/herbals/supplements?........ Yes ◯ No ◯
   If yes, pleas list: ______________________
5. (Women) Is there a chance you are pregnant? .... Yes ◯ No ◯
6. Do you take oral contraceptives? .... Yes ◯ No ◯
7. Are you allergic/ sensitive to: ◯None ◯Codeine ◯ Penicillin ◯ Local ◯Anesthetic ◯Latex ◯Pine ◯ Nuts ◯ Dyes
   Other: ______________________
8. Do you smoke, chew or use E-cigarettes? .... Yes ◯ No ◯
   If yes, please indicate which one(s), daily frequency and how long? ______________________
9. Do you have Diabetes? .... Yes ◯ No ◯
   If yes, please indicate ....◯ Type 1 ◯ Type 2 Last HbA1c date and level ______________________
10. Do you have, or have you ever had:

Heart trouble........	Yes ◯	No ◯
Heart murmur........	Yes ◯	No ◯
Heart surgery........	Yes ◯	No ◯
Heart pacemaker........	Yes ◯	No ◯
Rheumatic fever........	Yes ◯	No ◯
Congenital heart defects........	Yes ◯	No ◯
Artificial heart valve/stent graft....	Yes ◯	No ◯
Abnormal blood pressure........	Yes ◯	No ◯
Stroke........	Yes ◯	No ◯
Ulcers/ GERD........	Yes ◯	No ◯
Kidney trouble/ Dialysis........	Yes ◯	No ◯
Tuberculosis or lung disease........	Yes ◯	No ◯
Asthma........	Yes ◯	No ◯
Sinus trouble........	Yes ◯	No ◯
Epilepsy/ seizures........	Yes ◯	No ◯
Fainting spells........	Yes ◯	No ◯
Anemia........	Yes ◯	No ◯
Leukemia........	Yes ◯	No ◯
Excessive or prolonged bleeding........	Yes ◯	No ◯
Current INR: ______________		
Thyroid Problem........	Yes ◯	No ◯
Jaundice........	Yes ◯	No ◯
Hepatitis (Type)........	Yes ◯	No ◯
Cancer........	Yes ◯	No ◯
Chemotherapy/ radiation........	Yes ◯	No ◯
Arthritis........	Yes ◯	No ◯
Artificial Joint Replacement........	Yes ◯	No ◯
Cortico-Steroid treatment........	Yes ◯	No ◯
Osteoporosis/treatment w/Bisphosphonates....	Yes ◯	No ◯
HIV positive/ AIDS........	Yes ◯	No ◯
Oral herpetic lesions........	Yes ◯	No ◯
Sexually Transmitted disease........	Yes ◯	No ◯
Psychiatric care........	Yes ◯	No ◯
Glaucoma........	Yes ◯	No ◯
Hearing Impaired........	Yes ◯	No ◯
Chemical dependency........	Yes ◯	No ◯
Do you take pre-medication?........	Yes ◯	No ◯
If yes, for what reason (s)? ______________		

11. Have you had any other serious illness, hospitalization or accident?
    If yes, please explain: ______________________

Height: ______________ Weight: ______________

OVER ➡